MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2002

United HealthCare of Colorado, Inc.
8051 East Maplewood Avenue, Suite 300
Greenwood Village, Colorado 80111

NAIC Group Code 0707
NAIC Company Code 95090

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

United HealthCare of Colorado, Inc.
8051 East Maplewood Avenue, Suite 300
Greenwood Village, Colorado 80111

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2002

Examination Performed by
Jeffory A. Olson, CIE, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
Maggie Caouette
Amy Gabert
Kit Tucker

State Market Conduct Examiners

October 9, 2003

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of United HealthCare of Colorado, Inc. (the Company) was conducted pursuant to Section 10-16-416, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine health maintenance organizations. We examined the Company's records at its Denver office located at 8051 East Maplewood Avenue, Suite 300, Greenwood Village, Colorado, 80111 and at the Colorado Division of Insurance offices at 1560 Broadway, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2002, through December 31, 2002.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory Olson, CIE, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Maggie Caouette

Amy Gabert

Kit Tucker

MARKET CONDUCT EXAMINATION REPORT OF UNITED HEALTHCARE OF COLORADO, INC.

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COMPANY PROFILE

United Healthcare of Colorado, Inc. (the "Company") was incorporated under the laws of the State of Colorado as a for-profit corporation on February 24, 1986, under the name "MetLife HealthCare Network of Colorado, Inc." On March 20, 1986, the Company was granted a certificate of authority by the Colorado Division of Insurance to operate as a health maintenance organization (HMO). On July 11, 1995, the Company changed its name to "MetraHealth Care Plan of Colorado, Inc."

The Company became affiliated with UnitedHealth Group Incorporated, (formerly known as United HealthCare Corporation and consistently referred to as "United") after United purchased 100% of The MetraHealth Companies, Inc. on October 2, 1995. At the time of the acquisition of The MetraHealth Companies, Inc. by United, the Company was a wholly owned subsidiary of the MetraHealth Care Management Corporation. The Colorado Division of Insurance approved the acquisition on September 1, 1995. On May 1, 1996, the Company's name was changed to "United HealthCare of Colorado, Inc."

Today, United HealthCare of Colorado, Inc. (NAIC Company Code: 95090; NAIC Group Code: 0707) is a wholly owned subsidiary of UnitedHealthcare, Inc. ("Uhc"), a Delaware corporation. Uhc is a wholly owned subsidiary of United HealthCare Services, Inc. ("UHS"), a Minnesota corporation. UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated.

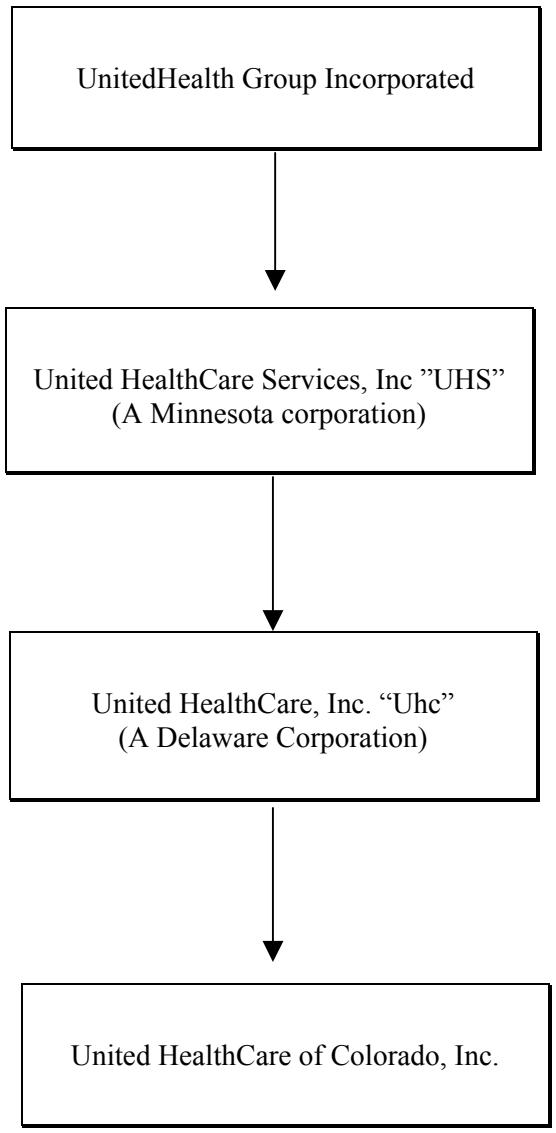
The Company, a for-profit HMO, offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers in the state of Colorado. The Company has entered into contracts with physicians, hospitals and other health care providers pursuant to which such providers deliver medical care to enrollees primarily on a modified fee-for-service basis.

United HealthCare, Inc. does not offer products on the individual level.

The following organizational chart shows the structure of United HealthCare of Colorado, Inc.

STRUCTURE AS OF DECEMBER 31, 2002

The following organizational chart depicts the Company's relationship within the corporate structure as of December 31, 2002.



Service Area

The Company is licensed to provide services in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Denver, Douglas, El Paso, Jefferson, Larimer, Lincoln, Otero, Park, Pueblo, Teller, and Weld counties in Colorado.

Enrollment As of 12-31-02:	71,436
Small Group:	35,035
Large Group:	36,401
Total Written Premium as of 12-31-02:	$ 206,949,129
Small Group Written Premium**:	$ 98,566,370
Large Group Written Premium**:	$ 107,286,863
Market Share (all Colorado HMO's):	6.55%

** As provided by the Company.

PURPOSE AND SCOPE OF EXAMINATION

State market conduct examiners with the Colorado Division of Insurance (DOI), in accordance with Colorado Insurance Law, Sections 10-1-201, 10-1-203, 10-1-204 and specifically 10-16-416, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of United HealthCare of Colorado, Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to Health Maintenance Organizations (HMO's). Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The limited market conduct examination covered the period from January 1, 2002, through December 31, 2002.

The examination included review of the following:

Company Operations/Management;
Contract Forms;
Rating;
Applications/Renewals;
Cancellations/Non-renewals/Declinations;
Claims Handling; and
Utilization Review.

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties, were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to small and large group health insurance reform laws as they pertained to health maintenance organizations. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any health maintenance organization.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and regulations. For this examination, special emphasis was given to small group reform, and the laws and regulations as shown in Exhibit 1.

During the exam, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although United HealthCare Insurance Company and United HealthCare of Colorado, Inc. are separate companies, there are many policies, procedures and forms that are common to both companies.

Therefore, it was agreed that in those cases where it appeared that a comment form may be applicable to both companies, the examiners would include an option for the Company to "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1101-10-3-1104	Unfair Competition - Deceptive Practices
Section 10-8-601-10-8-605	Small Employer Health Insurance Availability Program Act
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-401-10-16-427	Health Maintenance Organizations
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Regulation 1-1-4	Maintenance of Offices in this State
Regulation 1-1-7 (Revised)	Market Conduct Record Retention
Regulation 1-1-8	Penalties and Timelines Concerning Division Inquires and Document Requests
Regulation 4-2-5	Hospital Definition
Regulation 4-2-11	Individual and Group Health Insurance Rate Filings
Regulation 4-2-15	Required Provisions in Carrier Contracts with Providers and Intermediaries Negotiating on Behalf of Providers
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Regulation 4-6-5,	Implementation of Basic and Standard Health Benefit Plans

(Amended)	
Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Health Plans
Regulation 4-6-8	Concerning Small Employer Health Plans
Regulation 4-6-9	Conversion Coverage
Regulation 4-7-1	Health Maintenance Organizations
Regulation 4-7-2	Health Maintenance Organization Benefit Contracts and Services in Colorado

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous market conduct exam in 1998 and 1999, which covered the period January 1, 1997 through January 31, 1998. The Company also underwent a financial audit by the Colorado Division of Insurance in 1999, which covered the period of 1994 through 1998.

Contract Forms

The examiners reviewed the following forms:

- The Company's Basic and Standard HMO Plans, Co-payment Schedules, Evidences of Coverage and Schedule of Benefits;
- The Company's most commonly sold HMO group contracts marketed to small employers and business groups of one;
- The Company's HMO conversion contracts, application form, definitions, eligibility, and termination provisions; and
- The Company's group and employee HMO applications/enrollment forms and supporting documents.

These plans were issued and/or certified with the Colorado Division of Insurance (DOI) between January 1, 2002 and December 31, 2002.

Rating

The examiners reviewed the premium rates charged in the samples of the files selected in the Underwriting (new applications and renewals) section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

Applications

For the period January 1, 2002 through December 31, 2002, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- Fifty (50) small group new application files; and
- Fifty (50) renewed small group files.

Cancellations/Non-Renewals/Declinations

For the period January 1, 2002 through December 31, 2002, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- Fifty (50) small group cancellation/non-renewal files; and
- The entire population of thirty-four (34) declined small group files.

Claims

Utilizing ACL™ software, the examiners selected samples of 100 paid and 100 denied small group HMO claims that were received during the period of January 1, 2002 through December 31, 2002. These claims were reviewed for the Company's overall claims handling practices and to determine accuracy of processing. It was determined that a sample size of 100 claims was appropriate in both of the above samples.

In order to determine the Company's compliance with Colorado's prompt payment of claims law, the examiners reviewed the following random samples:

- Fifty (50) electronic claims paid or denied beyond thirty (30) days; and
- 100 non-electronic claims paid or denied beyond forty-five (45) days.

In addition, the examiners identified 289 claims out of a population of 64,501 denied and 4,527 claims out of a population of 380,951 paid small and large group claims that were not paid, or settled within ninety (90) days after receipt. These claims were reviewed to determine if they had been delayed due to fraud, and if not, if interest and penalties had been paid.

Utilization Review

The examiners reviewed the Company's utilization management program including policies and procedures. The examiners also reviewed the entire population of twenty-one (21) first level appeal files, the entire population of five (5) second level appeal files, and the entire population of one (1) external review file. A sample of fifty (50) utilization review reconsiderations out of a population of sixty-six (66) was also requested and reviewed. However, it was later determined that all but one of the fifty (50) files were not actually reconsiderations. Due to this information not being identified until near the end of the exam, and therefore lack of time to research and review possible other reconsiderations, utilization review reconsiderations are being omitted from this exam.

In addition, the examiners selected a sample of fifty (50) utilization review (UR) denial decision files from total populations of 1,096 and selected a sample of fifty (50) UR certification decisions from a total population of 2,633. These sample files were reviewed for the Company's overall UR handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of thirty-seven (37) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

Operations/Management: The examiners identified one (1) areas of concern in their review of the Company's operations/management.

1. Failure to correctly and completely list all applicable forms in the "Colorado Annual Report of Health Coverage Forms".

Contract Forms: The examiners identified thirteen (13) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and any riders).

1. Failure of the Company's forms to allow for coverage of otherwise eligible dependents who do not reside within the service area.

2. Failure of the Company's forms to provide coverage for dental care resulting from accidents in all instances required by law.

3. Failure of the Company's forms to provide a complete and accurate description of the required Hospice Care benefits.

4. Failure of the Company's Standard Health Benefit Plan forms to exclude copayments for physician ordered lab and x-ray services.

5. Failure of the Company's forms to provide durable medical equipment benefits in accordance with the law.

6. Failure of the Company's forms to include the provision of complaint forms to enrollees in its complaint procedures.

7. Failure of the Company's forms, in some instances, to limit the look-back period for medical information to five (5) years as required by law.

8. Failure of the Company's forms, in some instances, to allow for otherwise eligible employees to enroll in continuation coverage. *(This was prior issue E10 in the findings of the 1999 final examination report)*.

9. Failure of the Company's forms to contain a correct definition of a disabled dependent.

10. Failure of the Company's forms to provide for modification of health benefit plans in accordance with the requirements of Colorado insurance law.

11. Failure of the Company's forms to provide accurate information concerning premium rate setting.

12. Failure of the Company's forms to provide coverage for congenital defects and birth abnormalities as mandated by Colorado insurance law.

13. Failure of the Company's forms to provide correct information regarding changes to premium rates.

Rating: The examiners identified one (1) area of concern in their review of small group rates used between January 1, 2002 and December 31, 2002.

1. Failure to include required information concerning the choice of either the age-banded or the composite rates.

Applications: The examiners identified five (5) areas of concern in their review of small group contracts issued between January 1, 2002 and December 31, 2002.

1. Failure, in some instances, to secure and maintain signed applications and/or waivers of coverage for eligible employees and/or their dependents.

2. Failure, in some instances, to include the required Basic and Standard plan disclosure in small group application materials.

3. Failure to obtain the required employer provided listing of eligible dependents.

4. Failure, in some instances, to include the small group disclosure requirements in new application materials. (*This was prior issue G3 in the findings of the 1999 final examination report.)*

5. Failure, in some instances, to notify the Commissioner of Insurance and policyholders prior to the discontinuation of small employer group health benefit plans.

Cancellations/Non-Renewals/Declinations: There were four (4) areas of concern identified during the review of the small group and individual cancellation/non-renewal/declination files.

1. Failure, in some instances, to provide written notification of denials to small employers whose applications for coverage are denied. *(This was prior issue H2 in the findings of the 1999 final examination report.)*

2. Failure, in some instances, to guarantee issue coverage to small groups of 2-50 employees as required by Colorado insurance law.

3. Failure to examine all applicable tax returns when determining eligibility of business groups of one.

4. Failure, in some instances, to offer Basic and Standard Plan conversion coverage to terminating small employer groups.

Claims: The examiners identified four (4) areas of concern in their review of the claims handling practices of the Company.

1. Failure, in some instances, to request any necessary additional information and/or incorrect denial of eligible charges.

2. Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

3. Failure, in some instances, to pay interest and/or penalties on claims that were not paid, denied, or settled within the time periods required by Colorado insurance law.

4. Failure, in some instances, to process claims accurately.

Utilization Review: The examiners identified nine (9) areas of concern in their review of the Company's Utilization Review procedures.

1. Failure, in some instances, to make Utilization Review determinations and provide required notifications within the timeframes allowed under Colorado insurance law.

2. Failure, in some instances, to provide clear and specific notification in the case of utilization review approvals.

3. Failure, in some instances, to provide written notice of first level appeal decisions within twenty (20) working days.

4. Failure, in some instances, to include all required components in First Level appeal determination letters.

5. Failure, in some instances, to conduct first level appeal reviews using physicians who were not involved in the initial adverse determination.

6. Failure, in some instances, to notify member fifteen (15) days in advance of the hearing date for second level appeals.

7. Failure, in some instances, to ensure that second level appeal panels include a majority of health care professionals with appropriate expertise to review the case.

8. Failure to include all the required elements in written notifications of second level appeal rights.

9. Failure to include all required elements in the written notification to the covered person of second level appeal decisions, including the right to an independent external review in the case of adverse appeal determinations.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

UNITED HEALTHCARE OF COLORADO, INC.

COMPANY OPERATIONS/MANAGEMENT FINDINGS

Issue A1: Failure to correctly and completely list all applicable forms in the "Colorado Annual Report of Health Coverage Forms".

Section 10-16-107.2, C.R.S., Filing of health policies, states:

> (1) All sickness and accident insurers, *health maintenance organizations*, and nonprofit hospital and health service organizations authorized by the commissioner to conduct business in Colorado *shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado*. Such listing shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner. [Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law, in that its "Colorado Annual Report of Health Coverage Forms" for the year 2002:

1. Lists forms not in use during the 2002 calendar year. The filing lists forms with a 2003 effective date, but does not list the versions of these forms that were actually in use during 2002 calendar year. The Company's filing states:

form #	title	effective date of use
RXDC.H.02.CO	Outpatient Prescription Drug Rider	1/1/*2003*
BASCHCCO.01	CO Basic Health Benefit Plan	1/1/*2003*
STDCHCCO.01	CO Standard Health Benefit Plan	1/1/*2003*
PolicyStdBas.01.CO	CO Basic and Standard Group Policy	1/1/*2003*
BASCONVCHC.01	CO Conversion Policy-Basic Plan	1/1/*2003*
STDCONVCHC.01	CO Conversion Policy-Standard Plan	1/1/*2003*

2. Fails to completely disclose all forms in use for the 2002 calendar year. The filing lists forms in use for part of 2002, but does not list the forms in use prior to the listed effective dates. The Company's filing states:

form #	title	effective date of use
380-1474 1/02	Employee Enrollment	*4/15/2002*
380-1475 1/02	Employer Application (Groups with 100+ lives)	*4/15/2002*
380-1476 1/02	Employee Long Form Enrollment	*4/15/2002*
380-1477 10/02	Small Group Employer Application	*11/6/2002*

[Emphases added.]

Form	Date
Colorado Annual Report of Health Coverage Forms	December 2002

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107.2, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to correctly and completely list all applicable forms in its "Colorado Annual Report of Health Coverage Forms" as required by Colorado insurance law.

UNDERWRITING
CONTRACT FORM
FINDINGS

Issue E1: Failure of the Company's forms to allow for coverage of otherwise eligible dependents who do not reside within the service area.

Section 10-16-102, C.R.S., Definitions, states:

> (14) *"Dependent" means* a spouse, an unmarried child under nineteen years of age, *an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent* [emphases added], and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

Section 10-16-104, C.R.S., Dependent children, states:

> (6) (b) No entity described in paragraph (a) of this subsection (6) shall refuse to provide coverage for a dependent child under the health plan of the child's parent for the sole reason that the child:
>
> (I) *Does not live in the home of the parent applying for the policy*; or
>
> (II) *Does not live in the insurer's service area*, notwithstanding any other provision of law restricting enrollment to persons who reside in an insurer's service area; or … [Emphases added]

It appears that the Company's forms are not in compliance with Colorado insurance law in that they require a student dependent to reside within the Service Area to be eligible for coverage. Colorado law does not require a dependent child to reside within the Service Area of the HMO.

The Company's forms state:

Section 10: Glossary of Defined Terms

> "To be eligible for coverage under the Policy, a Dependent must reside within the Service Area or reside with the Subscriber who works within the Service Area."

Section 8: When Coverage Ends

> 1) "Your coverage ends on the [date][last day of the calendar month in which] you no longer reside or work in the Service Area. Coverage will end on the date of that move, even if you do not notify us. (This does not apply to an Enrolled Dependent child for whom the Subscriber is required to provide health insurance coverage through a Qualified Medical Child Support Order or other court or administrative order.) The Subscriber or the Enrolling Group must notify us if you move from the Service Area."

Forms

BASCHCCO.01
STDCHCCO.01
CHOICECO.01
SELECTCO.01
BASCONVCHC.01
STDCONVCHC.01

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why its forms should not be considered in violation of Sections 10-16-102 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all of its affected forms to reflect the correct eligibility requirements for dependents as required by Colorado insurance law.

Issue E2: Failure of the Company's forms to provide coverage for dental care resulting from accidents in all instances required by law.

Regulation 4-6-5, amended effective January 1, 2002, Implementation of basic and standard health benefit plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

> III. Rules
>
> A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.
>
> Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado
>
> I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."
>
> II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."
>
> 35. What Treatments and Conditions are Excluded under this Policy?
>
> Standard exclusions, including benefits covered by a no-fault auto policy or employers liability laws; care that is not medically necessary; cosmetic care; custodial care; *dental care except for accidents* [emphasis added] and anesthesia for dependent children as required by law…

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that benefits for dental care following an accidental injury are more restrictive than required by law. The Company's 2002 Choice HMO Standard and Basic Health Plan certificate of coverage forms limit benefits to treatment of a sound, natural tooth that is certified by the dentist or physician as a virgin or unrestored tooth.

2002 Choice HMO Standard and Basic Health Benefit Plan Certificate of Coverage, states:

> **4. Dental Services – Accident only**
>
> Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- *A virgin or unrestored tooth* [emphasis added], or

- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Forms	Date
BASCHCCO.01	1/1/2002
STDCHCCO.01	1/1/2002
BASCONVCHC.01	1/1/2002
STDCONVCHC.01	1/1/2002

Recommendation No. 3:

Within thirty (30) days the Company should provide documentation demonstrating why its forms should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all of its affected forms to modify the restrictions on dental coverage related to accidents to ensure compliance with Colorado insurance law.

Issue E3: Failure of the Company's forms to provide a complete and accurate description of the required Hospice Care benefits.

Regulation 4-2-8, amended effective February 1, 2001, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated pursuant to 10-1-109 and 10-16-104(8)(d), C.R.S., states:

> Section 2. Purpose
>
> The purpose of this regulation is to establish requirements for standard policy provisions, which *shall state clearly and completely the criteria for and extent of coverage for home health services and hospice care* ...[Emphasis added.]
>
> Section 5. Requirements for Hospice Care
>
> C. Benefits for Hospice Care Services.
>
> (3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:
>
> (a) Bereavement support services for the family of the deceased person during the *twelve month period following death* [emphasis added], and in no event shall this maximum benefit be less than $1150.
>
> (b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;
>
> (c) *Medical supplies*;
>
> (d) *Drugs and biologicals*;

(e) *Prosthesis and orthopedic appliances*;

(f) *Oxygen and respiratory supplies*;

(g) *Diagnostic testing*;

(h) *Rental or purchase of durable equipment*;

(i) *Transportation*;

(j) *Physicians services;*

(k) *Therapies including physical, occupational and speech; and*

(I) *Nutritional counseling by a nutritionist or dietitian*. [Emphases added.]

Regulation 4-6-5, amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, C.R.S., 10-16-105(7.2), C.R.S., and 10-16-108.5(8), C.R.S., states:

III. Rules

A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2002

I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard health Benefit Plan."

	BASIC HMO PLAN
	IN-NETWORK ONLY (out-of-network care is not covered except as noted)
26. HOSPICE CARE [22a.]	$50 copay inpatient per diem $20 copay home hospice per diem

	STANDARD HMO PLAN
	IN-NETWORK ONLY (out-of-network care is not covered except as noted)
26. HOSPICE CARE [22a.]	No copay (100% covered)

22a. Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Regulation 4-2-8.

It appears that the Company's forms are not in compliance with Colorado insurance law in that they do not provide a complete and accurate description of Hospice Care benefits. The Company's 2002 Choice Standard and Basic Health Benefit Plan certificate of coverage forms do not indicate that the following items are covered:

- Medical supplies;
- Drugs and biologicals;
- Prosthesis and orthopedic appliances;
- Oxygen and respiratory supplies;
- Diagnostic testing;
- Transportation;
- Physical, occupational and speech therapies;
- Nutritional counseling;
- Rental or purchase of durable equipment; and
- Physician services.

Additionally, the limitation of bereavement support services to the three month period following death appears to be more restrictive than that of Colorado insurance law.

The Company's 2002 Choice HMO Standard and Basic Health Benefit Plan Certificate of Coverage, states:

Hospice Care

State Mandate
Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members, the Covered Person's primary caregiver and for individuals with significant personal ties to the Covered Person. Benefits are available when hospice care is received from a hospice agency that is licensed and regulated by the Colorado Department of Public Health and Environment. Hospice care includes intermittent non-routine inpatient respite care on a short-term basis.

Benefits are limited to three benefit periods of three months per benefit period during the entire period of time you are covered under the Policy. *Benefits for bereavement support services are limited to $1,150 during the three month period following death*. [Emphasis added.]

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

Forms	Date
BASCHCCO.01	1/1/2002
STDCHCCO.01	1/1/2002
BASCONVCHC.01	1/1/2002
STDCONVCHC.01	1/1/2002

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-2-8 and 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct Hospice Care benefits as required by Colorado insurance law.

Issue E4: Failure of the Company's Standard Health Benefit Plan forms to exclude copayments for physician ordered lab and x-ray services.

Regulation 4-6-5, amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, C.R.S., 10-16-105(7.2), C.R.S., and 10-16-108.5(8), C.R.S., states:

III. Rules

B. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2002

III. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

	STANDARD HMO PLAN
	IN-NETWORK ONLY (out-of-network care is not covered except as noted)
14. LABORATORY & X-RAY[11]	No copay for physician-ordered services.

11. Includes low dose mammography screening not otherwise covered under the list of preventive care services, as mandated by Colorado law, Section 10-16-104(4), C.R.S.

It appears that the Company is not in compliance with Colorado insurance law in that its Choice HMO Standard Health Benefit Plan forms do not indicate that no copay is required for physician ordered Laboratory and X-Ray services. It appears that an additional copayment would be charged to the member for diagnostic or therapeutic services received at a hospital or ancillary facility even if they were ordered by a physician. The Company's 2002 Choice HMO Standard Health Benefit Plan states:

16. Outpatient Surgery, Diagnostic and Therapeutic Services

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Surgery and related services.
- Lab and radiology / X-ray.
- Mammography testing not otherwise described as Covered under Physician Office Services below.
- Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy).

Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	**Does Copayment Help Meet OOPM*?**
$50 per visit for outpatient surgery. *$15 per visit for diagnostic and therapeutic services.* [Emphasis added].	Yes

Forms	Date
STDCHCCO.01	1/1/2002
STDCONVCHC.01	1/1/2002

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to include a correct description of the copay requirements for lab and x-ray services in the Standard Health Benefit Plans as required by Colorado insurance law.

Issue E5: Failure of the Company's forms to provide durable medical equipment benefits in accordance with Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

14. Prosthetic devices.

    (d) Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the insured's treating physician.

    (e) Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.

    (f) A carrier may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to this subsection (14) shall be covered benefits only if the prosthetic devices are provided by a vendor and prosthetic services are rendered by a provider who contracts with or is designated by the carrier, to the extent that a carrier provides in-network and out-of-network services, the coverage for the prosthetic device shall be offered no less extensively.

Regulation 4-6-5, amended effective January 1, 2002, Implementation of basic and standard health benefit plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

III. Rules

A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2002

I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

III. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

	BASIC HMO PLAN
	IN-NETWORK ONLY (out-of-network care is not covered except as noted)
22. DURABLE MEDICAL EQUIPMENT[21]	**50% up to maximum $800/year paid by plan.**

	STANDARD HMO PLAN
	IN-NETWORK ONLY (out-of-network care is not covered except as noted)
22. DURABLE MEDICAL EQUIPMENT[21]	**50% up to maximum $800/year paid by plan.**

21. Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, *and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap*; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered. [Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that benefits for durable medical equipment are more restrictive than allowed by law. The Company's 2002 Choice HMO Basic and Standard Health Plan certificate of coverage forms fail to include reusable equipment for the treatment of diabetes as a covered benefit. The plan exclusions also state durable medical equipment and prescribed and non-prescribed outpatient supplies are not covered unless specifically stated as a covered benefit. Additionally, the Company limits benefits for the purchase, repair or replacement of a single purchase item to once every three years. Colorado insurance law requires coverage for necessary replacement of defective equipment without a specific time restriction except if the replacement is needed due to misuse or abuse by the insured.

2002 Choice HMO Basic and Standard Health Benefit Plan Certificate of Coverage, states:

6. Durable Medical Equipment

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.

- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, and connectors.)
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filers, and person comfort items are excluded from coverage.)

We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years. [Emphasis added.]

20. Prosthetic Devices

Prosthetic devices that replace a limb or body part including:

- Artificial limbs.
- Artificial eyes.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. *Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.* [Emphasis added.]

Forms	Date
BASCHCCO.01	1/1/2002
STDCHCCO.01	1/1/2002
BASCONVCHC.01	1/1/2002
STDCONVCHC.01	1/1/2002

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct benefits for durable medical equipment as required by Colorado insurance law.

Issue E6: Failure of the Company's forms to include the provision of complaint forms to enrollees in its complaint procedures.

Section 10-16-409, C.R.S., Complaint system, states:

> (1) (a) Every health maintenance organization *shall establish and maintain a complaint system which has been approved by the commissioner* [emphasis added], after consultation with the executive director, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

Regulation 4-7-2, amended effective July 1, 2000, Concerning The Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado, promulgated pursuant to 10-16-109, C.R.S., states:

> Section 5 Requirements for Benefit Contracts and Evidences of Coverage
>
> K. Complaint System
>
> *In compliance with 10-16-409, C.R.S., the contract and/or evidence of coverage shall contain a description of the HMO's method for resolving enrollee complaints*, *incorporating procedures to be followed by the enrollee in the event any dispute arises under the contract*. . . [Emphasis added.]
>
> Section 8 Other Requirements
>
> D. Complaint System
>
> 2. *An HMO shall provide complaint forms to be given to enrollees who wish to register written complaints. Such forms shall include the address and telephone number to which complaints must be directed and shall specify any required time limits imposed by the HMO*. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that the complaint procedures included in its Evidence of Coverage do not include a provision for providing a complaint form to be utilized when an enrollee wishes to submit a complaint in writing.

The Evidence of Coverage states only that to resolve a complaint, the member should contact the Company's customer service department, and that (s)he will be given the appropriate address if (s)he wishes to submit the complaint in writing.

The Certificate of Coverage, states:

Section 6: Questions, Complaints, Appeals

To resolve a question, complaint, or appeal, just follow these steps:

Contact Our Customer Service Department

. . . If you would rather send your complaint to us in writing at this point, the Customer Service representative can provide you with the appropriate address.

Forms	Date
CHOICECO.01	10/1/2001
SELECTCO.01	10/1/2001
BASCHCCO.01	1/1/2002
STDCHCCO.01	1/1/2002
BASCONVCHC.01	1/1/2002
STDCONVCHC.01	1/1/2002

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-409, C.R.S. and Amended Regulation 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to include a provision in its complaint procedures to indicate that complaint forms will be provided to individuals who wish to file a written complaint as required by Colorado insurance law.

Issue E7: Failure of the Company's forms, in some instances, to limit the look-back period for medical information to five (5) years as required by law.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

> (7) An individual, corporation, association, partnership, or any other entity engaged in the health insurance business subject to provisions of this section *shall not request or require from a small group applying for coverage, or from an individual in a small group applying for coverage, medical information going back more than five years from the date of application* [emphasis added]. Medical information which is more than five years old on any of the enrollee members of a small group shall not be used by the insurer in underwriting or setting premiums for the group. Nothing in this subsection (7) shall preclude a small group health insurer subject to the provisions of part 2 of this article from asking about the current health status of any of the individuals in a group applying for coverage or using such information on current health status to underwrite or set premiums for the group.

It appears that the Company's forms are not in compliance with Colorado insurance law in that individual enrollees of small employer groups are required to authorize the Company to obtain medical information without limiting the authorization to the maximum five (5) year look-back period limitation.

The Company's "Employee Enrollment Form", under the "Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage" section contained on the back of the application states the following:

"I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy."

Form	Date:
380-1474 Employee Enrollment Form	9/02

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to limit the look-back period to five (5) years as required by Colorado insurance law.

Issue E8: Failure of the Company's forms, in some instances, to allow for otherwise eligible employees to enroll in continuation coverage. *(This was prior issue E10 in the findings of the 1999 final examination report.)*

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

(2) Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.

(a) Every group contract or group service contract providing hospital services, medical-surgical services, or other health services for subscribers or enrollees and their dependents issued by a nonprofit hospital, medical-surgical, and health service corporation or a health maintenance organization operating with a certificate of authority pursuant to part 3 or 4 of this article shall contain a provision which permits every covered employee or enrollee of an employed group whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for such employee and the employee's dependents. Such provision shall conform to the requirements, where applicable, of paragraphs (b), (c), and (d) of this subsection (2).

(b) (I) An employee shall be eligible to make the election for such employee and the employee's dependents provided for in paragraph (a) of this subsection (2) if:

(A) The employee's eligibility to receive insurance coverage has ended for any reason other than discontinuance of the group contract in its entirety or with respect to an insured class;

(B) Any premium or contribution required from or on behalf of the employee has been paid to the termination date; and

(C) The employee has been continuously covered under the group contract, or under any group contract providing similar benefits which it replaces, for at least six months immediately prior to termination.

(III) The employer shall not be required to offer continuation of coverage of any person if such person *is covered* [emphasis added] by medicare, Title XVIII of the federal "Social Security Act," or medicaid, Title XIX of the federal "Social Security Act."

> (c) (I) Upon the termination of employment of an eligible employee, the death of any such employee, or the change in marital status of any such employee, the employee or dependent has the right to continue the coverage for a period of eighteen months after loss of coverage or until the employee or dependent becomes eligible for *other group coverage* [emphasis added], whichever occurs first. . . .

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that eligibility for continuation coverage is more restrictive than allowed by law. Continuation coverage cannot be denied because an individual is *eligible* for Medicare or Medicaid. Coverage may only be denied if the individual is *covered* under Medicare or Medicaid (*This was prior issue E10 from the 1999 Market Conduct Examination*). In addition, Continuation Coverage cannot be terminated solely because the individual has moved outside the service area. Members are eligible if they either live or work in the service area.

Certificate of Coverage, states:

Qualifying Events for Continuation Coverage under State Law

To qualify for continuation coverage under state law, the Covered Person must meet the criteria below: …

- The Covered Person is not *eligible* for Medicare or Medicaid.
- The Covered Person is not enrolled in Medicare.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates: …

- The date you move outside the Service Area.

Forms	Date
CHOICECO.01	10/1/2001
SELECTCO.01	10/1/2001
BASCHCCO.01	1/1/2002
STDCHCCO.01	1/1/2002

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to allow for qualified individuals to enroll in continuation coverage as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1997 through January 31, 1998, the Company was cited for failure to offer state continuation to, and/or to continue state continuation coverage of, some eligible Members. The violation resulted in Recommendation #26, that the Company revise its forms to either correctly specify that initial and continuing coverage is available for Medicare eligibles or to omit the exclusion of Medicare eligibles. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E9: Failure of the Company's forms to contain a correct definition of a disabled dependent.

Section 10-16-102, C.R.S., Definitions, states:

> 14. "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is *medically certified as disabled and dependent upon the parent*. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that coverage for a disabled dependent is more restrictive than permitted by law. Colorado law does not require, as a condition for coverage, a disabled dependent to be unable to be self-supporting or incapacitated. The only condition for coverage under the law for a medically certified disabled dependent is dependency upon the parent.

The Certificate of Coverage, states:

Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be *self-supporting* because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if *both* of the following are true regarding the Enrolled Dependent child:

- *Is not able to be self-supporting because of mental retardation or physical handicap*.
- Depends *mainly* on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is *incapacitated and dependent* unless coverage is otherwise terminated in accordance with the terms of the Policy.

We may continue to ask you for proof that the child continues to meet these conditions of *incapacity and dependency*. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's *incapacity and dependency* within 31 days of our request as described above, coverage for that child will end. [Emphases added.]

Forms	Date
CHOICECO.01	10/1/2001
SELECTCO.01	10/1/2001
BASCHCCO.01	1/1/2002
STDCHCCO.01	1/1/2002
BASCONVCHC.01	1/1/2002
STDCONVCHC.01	1/1/2002

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to contain a correct definition of disabled dependent as required by Colorado insurance law.

Issue E10: Failure of the Company's forms to provide for modification of health benefit plans in accordance with the requirements of Colorado insurance law.

Section 10-16-201.5(8), C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

> (a) With respect to benefits provided under a small group health benefit plan or individual health benefit plan renewed on or after January 1, 1999, a carrier may make reasonable modifications if:
>
> (I) *The modification is effective only upon renewal of such health benefit plan*;
>
> (II) The health benefit plan is uniformly modified for all groups and individuals covered by such health benefit plan;
>
> (III) To the extent that a health benefit plan already provides the benefits and coverages established in section 10-16-105(7.2) and rules and regulations promulgated thereunder, the proposed modifications to benefits and coverages do not fall below such requirements;
>
> (IV) *The proposed modification is provided to policyholders and the commissioner at least ninety days prior to the effective date of the modification; and*
>
> (V) *The carrier provides to each affected policyholder the opportunity to purchase any other health benefit plan offered by the carrier in such market*. [Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its Certificates of Coverage contain references to changing the provisions of the certificate without reference to the required ninety (90) day notification, or the offer of the opportunity to purchase any other health benefit plans offered by the carrier. Additionally, it appears that modifications made by amendment or rider may not be effective upon the renewal date of the group as stipulated by Colorado insurance law.

Certificate of Coverage, states:

> **Changes to the Document**
>
> *We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Certificate. When that happens we will send you a new Certificate, Rider or Amendment pages*. [Emphasis added.]
>
> No one can make any changes to the Policy unless those changes are in writing.

Amendments to the Policy

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statues and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are *effective 31 days after we send written notice to the Enrolling Group.*
- *Riders are effective on the date we specify.*
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.
  [Emphases added.]

Forms	Date
CHOICECO.01	10/1/2001
SELECTCO.01	10/1/2001
BASCHCCO.01	1/1/2002
STDCHCCO.01	1/1/2002

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to provide members with notification of plan changes according to the time frames required by Colorado insurance law.

Issue E11: Failure of the Company's forms to provide accurate information concerning premium rate setting.

Regulation 4-6-7, amended effective January 1, 2001, Concerning Premium Rate Setting for Small Group Health Plans, states:

> Section 5. Premium Rate Setting
>
> A. Calculating Premium Rates Adjusted for Case Characteristics
>
> (1) Index Rate – Each carrier offering a health benefit plan to groups in Colorado shall develop *a single index rate for all small group plans it offers*. *This single index rate is identical to a community rate for the company's universe of small group plans offered for new issue or renewal*. It should be calculated using the experience *for all small group plans*. The premium rate charged during a rating period, *applicable to all small employers*, *shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this Section 5.*
>
> (2) Plan Design Adjustment – The Index Rate may be adjusted to reflect differences attributable to different plan designs. If the small employer carrier elects to make this adjustment, the small employer carrier should calculate a rate adjustment factor for each small group plan design. *Differences in the rates for different benefit plans, for persons with the same case characteristics, shall be attributable to plan design only and shall not reflect actual or expected differences in costs or utilization attributable to the health status of those enrolling under different plans*…[Emphases added.]
>
> C. Rating Period
>
> The rating period for all small group health plans *shall be twelve (12) months* [emphasis added] unless:
>
> (1) A small employer carrier specifies in its rate filing a different rating period, which shall be the *same for all its health benefit plans issued or renewed in the same calendar month* [emphasis added], pursuant to Section 10-16-105(8)(c)(II), C.R.S.; and
>
> (2) The small employer carrier clearly discloses in all its small employer solicitation and sales materials exactly what the different rating period is, pursuant to Section 10-16-105(5)(b), C.R.S.

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its Group Policy for the Choice and Select Health Benefit Plans contains references to changing the schedule for rates that are outside the provisions allowed for premium adjustments as stipulated by

Colorado insurance law. Additionally, the language in the Group Policy indicates that health status is a factor used to set premiums for the group, which is prohibited by law.

Group Policy, Exhibit 1, states:

4. **Premiums**

We reserve the right to change the schedule of rates for Premiums, after a 31-day prior written notice [[1] on the first anniversary of the effective date of this Policy specified in the application or on any month due date thereafter, or *on any date the provisions of this Policy are amended. We also reserve the right to change the schedule of rates for Premiums, retroactive to the effective date, if a material misrepresentation relating to health status has resulted in a lower schedule of rates*.][[1]*at any time*.] [Emphasis added.]

Forms	Date
PolicyH.01.CO	10/1/2001

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to provide accurate information regarding changes in premium rates to ensure compliance with Colorado insurance law.

Issue E12: Failure of the Company's forms to provide coverage for congenital defects and birth abnormalities as mandated by Colorado insurance law.

Section 10-16-104 (1.7) C.R.S., Therapies for congenital defects and birth abnormalities, states:

> (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide *medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age.* [Emphasis added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its forms define a Congenital Anomaly as a physical developmental defect that is present at birth *and is identified within the first twelve months of birth.* [Emphasis added. This definition creates the potential to exclude coverage for these conditions during the first five years of life, in that a congenital defect or birth abnormality may have been present at birth, but may not have been identified within the first twelve months of life.

Certificate of Coverage, states:

> **Congenital Anomaly –** a physical developmental defect that is present at birth, *and is identified within the first twelve months of birth.* [Emphasis added.]

Forms	Dated
CHOICECO.01	10/1/2001
SELECTCO.01	10/1/2001
BASCHCCO.01	1/1/2002
STDCHCCO.01	1/1/2002
BASCONVCHC.01	1/1/2002
STDCONVCHC.01	1/1/2002

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to eliminate the requirement that congenital anomalies must be identified within the first twelve months of life, to ensure compliance with Colorado insurance law.

Issue E13: Failure of the Company's forms to provide correct information regarding changes to premium rates.

Section 10-16-105(8), C.R.S., Small group sickness and accident insurance- guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

> (a)(I) The premium rate charged during a rating period to small employers shall be based on a single, same index rate, applicable to all small employers, adjusted for case characteristics and coverage, …

Regulation 4-6-7, amended effective January 1, 2001, Concerning Premium Rate Setting for Small Group Health Plans, states:

> Section 5. Premium Rate Setting
>
> B. Allowable Rate Adjustment Factor for Small Group Plans Issued or Renewed on or After January 1, 1998
>
> The rate adjustment factor for small group plans issued or renewed on or after January 1, 1998, shall be 1.0. This means the case characteristics-adjusted index rate calculation pursuant to subsection A of Section 5 of this regulation *may not be further adjusted using any other factors* …[emphasis added]
>
> D. Administrative and Other Fees
>
> (1) Carriers and producers *shall not charge any additional fees whatsoever in addition to premium*. Separate administrative, processing, renewal, enrollment, and *other special charges are prohibited*. *Such charges must be built into the index rate and are not an allowable rate adjustment factor*. …[Emphases added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that its Group Policies indicate that rates may be adjusted at anytime whenever any change in law that affects the Company's expenses. Carriers may not charge any additional fees in addition to premium except for amounts necessary to recoup assessments for CoverColorado or other recoverable governmental charges. In addition, any change in the Company's small group rates must be filed with the Division of Insurance before the new rates can be used, regardless of the reason(s) that necessitated the change.

Group Policy, states:

3.3 Adjustments to the Policy Charge

. . . If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges shall be automatically added to the Premium. In addition, *any change in law or regulation that significantly affects our cost of operation shall result in an increase in Premium, in an amount we determine.* [Emphasis added.]

Forms	Date
POLICYH.01.CO	10/1/2001
PolicyStdBas.01.CO	1/1/2002

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S and amended Regulation 4-6-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to provide correct information regarding changes to rates to ensure compliance with Colorado insurance law.

RATE FINDINGS

Issue F1: Failure to include required information concerning the choice of either age-banded or composite rates.

Regulation 4-6-7(6), amended effective January 1, 2001, Concerning Premium Rate Setting for Small Group Health Plans, Use of Composite Rates, promulgated under the authority of Sections 10-1-109(1), 10-16-105(6.5), 10-16-105(7.2), 10-16-105(8)(f), and 10-16-109, C.R.S., states:

A. Small employer carriers may offer the small employer rates calculated by use of the following methods subject to the following restrictions:

(1) Four-tier family, age-banded rated calculated pursuant to Section 5 of this regulation; OR

(2) A choice between four-tier, age-banded rates, calculated pursuant to Section 5 of this regulation, and composite rates. It shall be construed that the small employer carrier had offered the small employer a choice between the two methods if, at initial application and *at each renewal*:

(a) Both methods are offered to the small employer, *with the difference clearly explained in writing*; *OR*

(b) *The small employer is given a written option to indicate that: 1) both rating methods need be presented; or 2) only age banded rates need be presented; or 3) only the composite rate need be presented. This indication may be a check-off on* the application or *renewal form or similar form that complies with this section*. [Emphases added.]

B. Small employer carriers may offer small employers composite rates as an alternative to four-tier family, age-banded rates calculated pursuant to Section 5 of this regulation *if all of the following conditions are met* [emphasis added]:

(1) The small employer carrier makes the same offer across its entire book of Colorado small group business where an employer has ten (10) or more eligible employees. If the small employer carrier makes this offer to all small employers having ten (10) or more eligible employees, then the small employer carrier **may** also offer composite rates to small employers having fewer than ten (10) eligible employees. The small employer carrier must establish a pre-determined minimum size for offering composite rates. The same offer must be made available to all small employers having at least this pre-determined number of eligible employees.

(2) *The small employer carrier must clearly state on its* application and *renewal forms for all its small group products the differences between age-banded and composite rates and that either:*

(a) *The minimum number of eligible employees for calculating composite rates is ten (10) and that all small employers with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates, and have the right to see them calculated either or both ways*; [Emphases added.] OR

(b) If the number of eligible employees is less than ten (10), the small employer carrier shall state the minimum number and that all small employers with at least this minimum number of eligible employees are entitled to a choice of composite rates or four-tier, age-banded rates and have the right to see them calculated either or both ways.

Small Group Renewals Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,452	50	50	100%

It appears that the Company is not in compliance with Colorado insurance law in that its small employer renewal forms do not include the required information stating that employer groups with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates; that employer groups have the right to see what the premium would be quoted either way; and to provide an explanation of the differences between the two rating methods.

The examiners requested a sample of fifty (50) files systematically selected from a total population of 2,452 small group renewal files for groups that were renewed during the examination period of January 1 to December 31, 2002. Of the fifty (50) renewal files reviewed, none of the files contained the required small group rating disclosure.

The Company's "Basic and Standard Rate Disclosure" form states "For groups of 10-50 eligible employees, composite rates are also available." However, this disclosure does not meet the small group rating disclosure requirements. The Company's renewal rate quotes do not contain all of the required rate disclosure information. Since the Company has chosen to offer composite rates as an alternative to four-tier family, age-banded rates, it must provide the required disclosure information on its renewal forms.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why its forms should not be considered in violation of Amended Regulation 4-6-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to provide the required information concerning the group's right to see renewal rates quoted using either age-banded or composite rates, and to explain differences between the two methods as required by Colorado insurance law.

UNDERWRITING
APPLICATIONS/RENEWALS
FINDINGS

Issue G1: Failure, in some instances, to secure and maintain signed applications and/or waivers of coverage for eligible employees and/or their dependents in the waiting period at the time of the initial issue or renewal of the group.

Regulation 4-6-5, amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, Rules, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), and 10-16-108.5(8), C.R.S., states:

> Standard and Basic Health Benefit Plan Policy Requirements for the State of Colorado
>
> V. All basic and standard health benefit plans shall also comply with the following requirements:
>
> F. Enrollment – *To enroll an employee and dependents, the carrier shall require that*:
>
> 1. Employers:
>
> a. Submit a written request for coverage;
> b. Provide information necessary to determine eligibility; and
> c. Agree to pay the required premium.
>
> 2. *Eligible employees, on a form made available by the employer:*
>
> a. *Submit a written request for coverage for himself/herself and any dependents*; and
> b. Provide information necessary to determine eligibility, if it is required. [Emphases added.]

Regulation 4-6-8(5)(B), amended November 1, 1997, Concerning Small Employer Health Plans, Issuance of Coverage, Determining Who is an Eligible Employee, Dependent, promulgated under authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214(1)(d), and 10-16-708, C.R.S., states:

> (4) *A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an employee (or each employer-determined eligible employee and their dependents if this is different than the list of eligible employees) who declines an offer of coverage under a health benefit plan provided to a small employer*. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage (e.g., covered under spouse's plan, can't afford coverage, etc.) be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for all active employees. [Emphases added.]

New Small Group Application Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,402	50	22	44%

Small Group Renewals Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,452	50	12	24%

It appears that the Company is not in compliance with the requirements of Colorado insurance law in that, in some instances, it did not obtain either a completed application or a waiver of coverage for all eligible employees and their dependents of small employers who purchased or renewed health benefit plans issued by United HealthCare of Colorado, Inc.

The examiners reviewed a systematically selected sample of fifty (50) new small group application files from a total population of 1,402 new groups sold during the examination period of January 1 to December 31, 2002. Of the fifty (50) files reviewed, nineteen (19) files did not contain a total of forty-nine (49) required waivers of coverage for eligible employees and/or their dependents.

Additionally, three (3) files did not contain either a completed application or a waiver of coverage from employees who were in the waiting period at the time the group coverage was initially effective, and who subsequently became eligible for coverage.

The examiners also reviewed a systematically selected sample of fifty (50) small employer group renewal files from a total population of 2,452 small employer groups renewed during the examination period of January 1 to December 31, 2002. Of the fifty (50) files reviewed, the Company was unable to provide nine (9) applications or waivers of coverage in eight (8) files pertaining to nine (9) individuals. Additionally, four (4) files did not contain a total of seven (7) required applications or waivers of coverage forms for eligible employees and/or their dependents that were eligible for coverage subsequent to the issuance of the original group contract.

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-6-5 and 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all required applications and/or waivers of coverage are secured and maintained upon the initial issue of the small employer group or subsequent to an employee in the waiting period at initial application becoming an eligible employee as required by Colorado insurance law.

Issue G2: Failure, in some instances, to include the required Basic and Standard plan disclosure in small group application materials.

Regulation 4-6-5(III)(E), amended effective January 1, 2002, Implementation of Basic and Standard Health Benefit Plans, Rules, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

> The following disclosure statement, prominently displayed in a clear and conspicuous manner for printed materials, electronic or internet-based communications shall appear on all small employer marketing materials (except Colorado Comprehensive Health Benefit Plan Description Form pursuant to Colorado Division of Insurance Regulation 4-2-20), *small employer application forms*, [emphasis added] and small employer renewal notices, and on all written refusals to insure which are related to health coverage for a business group of one.
>
> "COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2 – 50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW."

Small Group Application Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,402	50	14	28%

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 1,402 representing new small group applications for coverage during the period January 1 through December 31, 2002. Based on the files examined, it appears that the Company was not in compliance with Colorado insurance law in that fourteen (14) of the files did not contain the required disclosure statement on the applications.

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all new small group application materials contain the required disclosure as required by Colorado insurance law.

Issue G3: Failure to obtain the required employer provided listing of eligible dependents.

Regulation 4-6-8, amended effective November 1, 1997, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214 (1)(d), and 10-16-708, C.R.S., states:

> Section 5. Issuance of Coverage
>
> B. Determining Who is an Eligible Employee, Dependent
>
> 3) A small employer carrier shall require each small employer that applies for coverage with an effective date on or after January 1, 1995, as part of the application process, to provide *a complete list of eligible* employees *and dependents of eligible employees, and a list of employer-determined eligible* employees *and dependents, if this is a different list.* [Emphases added.] The small employer carrier may require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.

Small Group Application Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,402	50	50	100%

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 1,402 representing new small group applications received during the exam period of January 1 through December 31, 2002. Based on the files examined, it appears that the Company is not in compliance with Colorado insurance law in that none of the sample files contained a list of eligible dependents.

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all small employer groups complete an employer provided listing of eligible dependents as required by Colorado insurance law.

Issue G4: Failure, in some instances, to include the small group disclosure requirements in new application materials. *(This was prior issue G3 in the findings of the 1999 final examination report.)*

Regulation 4-6-8(9), amended effective November 1, 1997, Concerning Small Employer Health Plans, Disclosure requirements, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-214(1)(d), and 10-16-708, C.R.S., states:

> (A) Pursuant to Sections 10-16-105(5), as amended by Senate Bill 97-54, and 10-16-704(9), C.R.S., small employer carriers shall provide, on all printed marketing and solicitation materials for their small group health products and in a separate boxed section with bold type no less than twelve (12) point, a clearly written disclosure that:
>
> (1) Identifies the class of business;
>
> (2) Specifies case characteristics and rating factors used in setting new and renewal rates and the extent to which they impact premiums;
>
> (3) Explains the employer's right to renew;

Small Group Application Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,402	50	14	28%

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 1,402 representing new small group applications for coverage received during the period January 1 through December 31, 2002. Based on the files examined, it appears that the Company is not in compliance with Colorado insurance law in that fourteen (14) of the files do not appear to contain the required Small Employer Health Plan disclosure.

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all small employer group application materials contain the required small group disclosure as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1997 through January 31, 1998, the Company was cited for failure to comply with disclosure requirements concerning setting of new and renewal rates and premium impact. The violation resulted in Recommendation #60, that the Company revise its solicitation materials to include the required disclosure statement. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue G5: Failure, in some instances, to notify the Commissioner of Insurance and policyholders prior to the modification and/or discontinuation of small employer group health benefit plans.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

> (6) A group health benefit plan carrier *may discontinue offering a particular type of group health coverage if:*
>
> (a) The group health *carrier provides notice of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage* to each policyholder provided this type of coverage and each certificate holder, participant, and beneficiary covered by such a policy; [emphases added]
>
> (8) (a) With respect to benefits provided under a small group health benefit plan or individual health benefit plan renewed on or after January 1, 1999, a carrier may make reasonable modifications if:
>
> (I) The modification is effective only upon renewal of such health benefit plan;
> (II) The health benefit plan is uniformly modified for all groups and individuals covered by such health benefit plan;
> (III) To the extent a health benefit plan already provides the benefits and coverages established in section 10-16-105 (7.2) and rules and regulations promulgated thereunder, the proposed modifications to benefits and coverages do not fall below such requirements;
> (IV) *The proposed modification is provided to policyholders and the commissioner at least ninety days prior to the effective date of the modification* [emphasis added]; and
> (V) The carrier provides to each effected policyholder the opportunity to purchase any other health benefit plan offered by the carrier in such market.

Small Group Renewals Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,452	50	39	78%

It appears that the Company is not in compliance with Colorado insurance law in that it modified and/or discontinued some of its HMO small employer group health benefit plans and replaced them with new plan designs without the required notice to the Commissioner of Insurance.

The examiners reviewed a systematically selected sample of fifty (50) small employer group renewal files from a total population of 2,452 small employer groups renewed during the examination period of January 1 to December 31, 2002. Of the fifty (50) files reviewed, thirty-nine (39) groups with a renewal

date of March 1, 2002, were notified that effective on their renewal date, their current health benefit plan was no longer being offered and was being replaced by new plan designs. However, it does not appear that these modifications and/or discontinuations were communicated to the Commissioner of Insurance.

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that the Commissioner of Insurance and all policyholders are notified prior to the modification and/or discontinuation of any health benefit plan as required by Colorado insurance law.

UNDERWRITING
CANCELLATIONS/NON-RENEWALS/DECLINATIONS
FINDINGS

Issue H1: Failure, in some instances, to provide written notification of denials to small employers whose applications for coverage are denied. *(This was prior issue H2 in the findings of the 1999 final examination report.)*

Section 10-16-108.5, C.R.S., Fair marketing standards, states:

> (7) *Any denial by a carrier of an application for coverage from an individual or a small employer, shall be in writing and shall state any reason for the denial.* [Emphasis added.]

DECLINED SMALL GROUP FILE SAMPLE – Written Notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
34	34	4	12%

The examiners reviewed the files for the entire population of thirty-four (34) small groups whose applications for coverage were declined during the period January 1, 2002 through December 31, 2002. It appears the Company is not in compliance with Colorado insurance law in that four (4) files did not contain evidence that a written denial had been provided to the applicant

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 10-16-108.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to include the required written notification to all small employers who are denied coverage as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 1997 through January 31, 1998 the Company was cited for failure to notify or incomplete notification of denial of coverage. The violation resulted in Recommendation #63, that the Company revise its procedures and forms to ensure that written denials are issued with all the information required by Regulation. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue H2: Failure, in some instances, to guarantee issue coverage to small groups of 2-50 employees as required by Colorado insurance law.

Section 10-16-102, C.R.S., Definitions, states:

(6) (a) "Business group of one" means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works twenty-four hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage, has taxable income as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes which generated taxable income in one of the two previous years or from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of any consecutive three-year period. For the purposes of this subsection (6), "substantial part of such individual's income" means income derived from business activities of the *business group of one* that are sufficient to pay for annual health insurance premiums for the *business group of one*. [Emphases added.]

(15)(a) "Eligible employee" means an employee who has a regular work week of twenty-four or more hours and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.

(b) Notwithstanding any provision of law to the contrary, an eligible employee of a small employer *who could also be considered a dependent of the small employer* [emphasis added] shall receive taxable income from such small employer in an amount equivalent to minimum wage for working twenty-four hours per week on a permanent basis in order for the employer group to be considered a business group of two or more.

(40) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, the majority of whom were employed within this state and that was not formed primarily for the purpose of purchasing insurance. On and after January 1, 1996, "small employer" includes a business group of one. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

> (7.3)(a) Except as otherwise provided in this subsection (7.3), effective January 1, 1995, every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to such small employers the choice of a basic health benefit plan or a standard health benefit plan. Effective July 1, 1997, every small employer carrier shall also offer to small employers a choice of all the other small group plans the carrier markets in Colorado; except that this requirement shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group market only through one or more bona fide association plans and except as provided in paragraph (i) of this subsection (7.3).
>
> (c) (I) Effective January 1, 1995, a small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for such health benefit plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with this article. Effective July 1, 1997, a small employer carrier shall also issue any of its other small employer plans to any small employer that applies for such a plan; except that this requirement shall not apply to a business group of one where the business group of one does not meet the carrier's normal and actuarially-based underwriting criteria. The requirements of this subparagraph (I) shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group market only through one or more bona fide association plans and except as provided in paragraph (i) of this subsection (7.3).

Regulation 4-6-8, amended effective November 1, 1997, Concerning Small Employer Health, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(I), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214 (1)(d), and 10-16-708, C.R.S., states:

> Section 5. Issuance of Coverage
>
> B. Determining Who is an Eligible Employee, Dependent
>
> 3) A small employer carrier shall require each small employer that applies for coverage with an effective date on or after January 1, 1995, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list. *The small employer carrier may require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.* [Emphasis added.]

SMALL GROUP DECLINED FILE SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
34	34	3	9%

The examiner reviewed the entire population of thirty-four (34) small groups whose applications for coverage were declined during calendar year 2002. It appears that the Company is not in compliance with law in that three (3) of the groups, appeared to meet the requirements to be eligible for small group coverage, but were incorrectly declined. It appears that in some cases, the Company requires groups of 2-50 employees to provide income tax documentation with their applications in order to prove sufficient income to pay premiums. Although Colorado insurance law does permit insurance companies to request copies of the W2 Summary Wage and Tax Forms in order to verify employee eligibility, other income tax information to verify sufficient income cannot be requested except for business groups of one.

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-102 and 10-16-105, C.R.S, and Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has changed its procedures to ensure that groups of 2-50 eligible employees are guaranteed issuance of coverage as required by Colorado insurance law.

Issue H3: Failure to examine all applicable tax returns when determining eligibility of business groups of one.

Section 10-16-102, C.R.S., Definitions, states:

> (6) (a) "Business group of one" means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works twenty-four hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage, has gross income as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes *which generated gross income from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of the most recent consecutive three-year period.* [Emphasis added.] For the purposes of this subsection (6), "substantial part of such individual's income" means income derived from business activities of the business group of one that are sufficient to pay for annual health insurance premiums for the business group of one.

SMALL GROUP DECLINED FILE SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
34	34	11	32%

The examiners reviewed the entire population of thirty-four (34) small groups whose applications for coverage were declined during calendar year 2002. Eleven (11) of these declinations appeared to involve business groups of one. It appears that the Company is not in compliance with Colorado insurance law in that in all eleven (11) cases involving business groups of one, only one year of tax records was reviewed, rather than the records from the most recent consecutive three (3) year period. None of the files examined contained any evidence that the Company obtained tax information for the entire three (3) years or that it requested tax information for another year if the information initially provided did not show sufficient income.

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it modified its procedures pertaining to reviewing tax documentation to ensure compliance with Colorado insurance law.

Issue H4: Failure, in some instances, to offer Basic and Standard Plan conversion coverage to terminating small employer groups.

Section 10-16-108(4) C.R.S., Conversion and continuation privileges, Special provisions for small group health benefit plans, states:

> (a) Effective January 1, 1995, *each small employer carrier shall*, *upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan* [emphasis added], except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policy holder exercising the right to cancel.
>
> (c) Each small employer carrier shall offer the choice of a basic or standard health benefit plan to any individual who loses nexus to existing small group coverage; except that:
>
> (I) If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of this paragraph (c) shall not apply to such an individual; and
>
> (II) If an individual lost nexus to group coverage for fraud or abuse in procuring or utilizing coverage, then the provisions of this paragraph (c) shall not apply to such an individual.

SMALL GROUP CANCELLED FILE SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
691	50	17	34%

The examiners reviewed a sample of fifty (50) files that were systematically selected from a population of 691 files identified as small group cancellations during the exam period of January 1, 2002 through December 31, 2002. It appears that the Company is not in compliance with the requirements of Colorado insurance law in that in seventeen (17) cases, upon the termination of the group policy for reasons other than replacement of coverage, the Company failed to offer to each member of the terminating small group *a choice of the Basic or Standard Health Benefit Plan* as required by law. It appears that in some cases, the Company supplied to the terminating employer, a generic letter directing the members to refer to their contract documents to determine if a conversion policy was available to them. The letter states:

Notice of Termination of Group Coverage

This is to notify you that your group coverage with UNITED HEALTHCARE is terminating. The termination date of your group coverage is shown above.

As a result of termination of your group coverage, certain rights may become available to you. We urge you to refer to your contract documents in order to determine what rights, if any, are available to you.

. . . Group Health Conversion (Refer to your contract documents)

When a privilege of conversion of group health coverage is present in your contract documents, you must exercise the privilege within 31 days after the date of termination of group coverage. If you wish to exercise any available group health conversion privilege, you should contact the Conversion Customer Service Unit. . . .

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that a choice of the Basic or Standard Health Benefit Plans is offered to each member of the group whose policy is terminating as required by Colorado insurance law. .

CLAIMS
FINDINGS

Issue J1: Failure, in some instances, to request any necessary additional information and/or incorrect denial of eligible charges.

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of the section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* [Emphasis added.] The person receiving a request for additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process.

DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
64,345	100	14	14%

From a population of 64,345 claims received from January 1, 2002, through December 31, 2002, a systematically selected a sample of 100 claims was reviewed.

It appears that the Company is not in compliance with Colorado insurance law in that at the time the claims were denied, it appears that the Company:

- in ten (10) cases, was in possession of the information it needed to properly adjudicate the claims; and

- in four (4) cases it failed to request any required additional information prior to denying the claim.

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its quality controls to ensure that its processing staff is properly trained to request any additional information necessary to resolve a claim, and to make appropriate decisions when all required information is present, to avoid denying eligible claims as required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the carrier's standard claim form with all required fields completed with correct and complete information in accordance with the carrier's published filing requirements. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.* [Emphasis added.]
>
> (c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphasis added.]

CLEAN ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,343*	50	38	76%

(*1% of all electronic claims)

CLEAN NON-ELECTRONIC CLAIMS PROCESSED OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,673*	100	78	78%

(*5% of all non-electronic claims)

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
4,816*	N/A	4,816	100%

(*1% of all processed claims)

The examiners reviewed a population of 329,444 claims, which represented all HMO claims that had been submitted to the Company electronically, and 110,321 claims representing all HMO claims that had been submitted in paper form. Using ACL™ software, the examiners identified a population of 3,343 electronic claims not paid, denied, or settled within thirty (30) days, and a population of 5,673 non-electronic claims not paid, denied, or settled within forty-five (45) days. The examiners selected a systematic sample of fifty (50) claims from the population of electronic claims over thirty (30) days, and a sample of 100 non-electronic claims over forty-five (45) days.

In addition, the examiners identified 4,816 claims out of a total population of 439,765 claims that were not paid, denied, or settled within ninety (90) days. None of these claims included any indication that they had been delayed due to fraud.

It appears that the Company is not in compliance with Colorado law in that:

- Thirty-eight (38) of the fifty (50) electronic claims reviewed appeared to represent clean claims, but were not paid or settled within thirty (30) days;
- Seventy-nine (79) of the 100 non-electronic claims reviewed appeared to represent clean claims but were not paid or settled with forty-five (45) days;
- 4,816 of the total population of 439,765 claims did not appear to involve fraud, but were not paid, denied, or settled within ninety (90) days.

Recommendation No. 26:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all clean electronic claims are paid, denied, or settled within thirty (30) days; all clean non-electronic claims are paid, denied, or settled with forty-five (45) days; and except where fraud is involved, all claims are paid, denied, or settled within ninety (90) days as required by Colorado insurance law.

Issue J3: Failure, in some instances, to pay interest and/or penalties on claims that were not paid or settled within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.* [Emphasis added.]

(a) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to three percent of the total amount ultimately allowed on the claim. Such penalty shall be due on the ninety-first day after receipt of the claim by the carrier.

PAID ELECTRONIC CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,343*	50	25	50%

(*1% of all electronic claims)

PAID NON-ELECTRONIC CLAIMS OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,673*	100	33	33%

(*5% of all non-electronic claims)

PAID CLAIMS OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
4,816*	N/A	4,816	100%

(*1% of all processed claims)

Using ACL™ software, the examiners reviewed the entire population of 439,765 HMO paid claims provided by the Company. The examiners identified 4,816 claims out of the population of 439,765 paid claims that appear not to have been paid or settled within the ninety (90) days allowed by law. The claims data provided to the examiners by the Company did not indicate that the required penalty payment for unsettled claims over ninety (90) days had been paid.

The examiners also identified a population of 3,343 claims that were not paid or settled within thirty (30) days and a population of 5,673 claims that were not paid or settled within forty-five (45) days. A sample of fifty (50) claims over thirty (30) days and 100 claims over forty-five (45) days were systematically selected from each of these populations, respectively. From these samples, it was determined that thirty-eight (38) claims out of the fifty (50) electronically submitted claims not paid or settled within thirty (30) days and thirty-four (34) claim out of the 100 non-electronically submitted claims not paid or settled within forty-five (45) days were clean claims and therefore should have been paid or settled within the required timeframes.

It appears that the Company is not in compliance with Colorado insurance law in that twenty-five (25) of the fifty (50) claims paid over thirty (30) days and thirty-three (33) of the 100 non-electronic claims over forty-five (45) days did not include payment of the required ten (10) percent annual interest on the amount ultimately allowed on the claim, accruing from the date the payment was made.

It also appears that the Company is not in compliance with Colorado insurance law in that it failed to pay a three (3) percent penalty of the total amount ultimately allowed on the claim to the insured or health care provider on the ninety-first (91st) day for all claims not paid or settled within ninety (90) days.

Recommendation No. 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that interest is paid on clean, electronic claims not paid within thirty (30) days, all clean, non-electronic claims not paid within forty-five (45), and a three percent (3%) penalty is paid on the ninety-first (91st) day for all claims not paid within ninety (90) days. The Company should work with the Division of Insurance to ensure that all past due interest and penalties are paid.

Issue J4: Failure, in some instances, to process claims accurately.

Section 10-3-1104(1), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices,

(f) Unfair discrimination states:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; …

HMO PAID CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
375,420	100	8	8%

Systematically selected samples were chosen for review of processing from the population of HMO claims received from January 1, 2002 through December 31, 2002. The populations, sample sizes, number of exceptions and percentage to the sample are reflected above. It appears that the Company is not in compliance with Colorado insurance law in that eight (8) claims do not appear to have been processed correctly based on a review of the information provided. The errors included incorrect application of copays, coinsurance, and deductibles.

Recommendation No. 28:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its claims processing quality controls to ensure that all claims are investigated properly to determine the proper allocation of benefits to ensure compliance with Colorado insurance law.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure, in some instances, to make Utilization Review determinations and provide required notifications within the timeframes allowed under Colorado insurance law.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

Section VI. Procedures for Review Decisions

A. A health carrier shall maintain written procedures for making utilization review decisions and for notifying covered persons and providers acting on behalf of covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.

B. For prospective review determinations, a health carrier *shall make the determination within two (2) working days of obtaining all necessary information* [emphasis added] regarding a proposed admission, referral, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required. In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, the carrier shall request in writing, within two working days, the additional information needed. The carrier shall allow twenty (20) calendar days to receive the requested information. Within two (2) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination based on the available information and provide notification as specified in paragraphs (1) and (2) below.

   1) In the case of a determination to certify an admission, procedure or service, the carrier *shall notify by telephone the provider rendering the service within one (1) working day of making the initial certification*; and *shall provide written or electronic confirmation of the telephone notification to the covered person and/or the provider within two (2) working days of making the initial certification.* [Emphases added.]

   2) In the case of an adverse determination, the carrier *shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination*; [Emphasis added.] and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within one (1) working day of making the adverse determination.

C. 1) For concurrent review determinations, a health carrier *shall make the determination within one (1) working day of obtaining all necessary information.* [Emphasis added.]

2) In the case of a determination to certify an extended stay or additional services, the carrier *shall notify by telephone the provider rendering the service within one (1) working day of making the certification*; and *shall provide written or electronic confirmation to the covered person and/or the provider within one (1) working day after the telephone notification.* The written or electronic notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services. [Emphases added.]

3) In the case of an adverse determination, the carrier *shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination*; [Emphasis added.] and shall provide written or electronic confirmation to the covered person and the provider within one (1) working day after the telephone notification. The service shall be continued without liability to the covered person until the covered person and the provider rendering the service have been notified of the determination.

D. For retrospective review determinations, a health carrier *shall make the determination within thirty (30) working days of receiving all necessary information*. [Emphasis added.] In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, the carrier shall request in writing, within two (2) working days, the additional information needed. The carrier shall allow twenty (20) calendar days to receive the requested information. Within thirty (30) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination based on the available information and provide notification as specified in paragraphs (1) and (2) below.

1) In the case of a certification, the carrier *shall notify in writing the covered person and the provider rendering the service within five (5) working days of making the determination to provide coverage.* [Emphasis added.]

2) In the case of an adverse determination, the carrier *shall notify in writing the provider rendering the service and the covered person within five (5) working days of making the adverse determination.* [Emphasis added.]

E. A written notification of an adverse determination shall include the principal reason for the determination, the instructions for initiating an appeal or reconsideration of the determination, *including expedited appeals, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and*

who follows the procedures for a request. [Emphasis added.] A carrier shall specify that such an appeal process shall include a two-level internal review, except as provoked for in section 8.I.A.5. of this regulation.

APPROVED UR DECISIONS - DETERMINATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,633	50	9	18%

APPROVED UR DECISIONS – TELEPHONE NOTIFICATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,633	50	22	44%

APPROVED UR DECISIONS – WRITTEN NOTIFICATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,633	50	17	34%

The examiners reviewed a systematically selected sample of fifty (50) files from a summarized population of 2,633 utilization review approvals made during the examination period. It appears that the Company is not in compliance with law in that:

1. Information in nine (9) of the files indicated that the determination to certify the requested admission, procedure or service had not been made within two (2) working days in the case of prospective reviews, or within one (1) working day in the case of concurrent reviews.

2. Twenty-two (22) files did not include documentation that the provider had been notified by telephone within one (1) working day of making the initial certification.

3. Seventeen (17) files did not include documentation that the covered person and/or the provider had been provided with written or electronic confirmation of the telephonic notification within two (2) working days for the prospective review determinations, within one (1) working day for concurrent review determinations, or within five (5) working days for retrospective reviews.

UTILIZATION REVEIW DENIALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
132	49	3	6%

UTILIZATION REVIEW DENIALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
132	49	16	33%

UTILIZATION REVIEW DENIALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
132	49	4	8%

The examiners requested a sample of fifty (50) files from a summarized population of 132 utilization review denials made during the examination period. The Company was unable to provide one (1) file, which resulted in a sample of forty-nine (49) files. It appears that the Company is not in compliance with Colorado insurance law in that:

1. Information in three (3) of the files indicates that the determinations for the requested admission, procedure or service had not been made within two (2) working days in the case of prospective reviews, within one (1) working day in the case of concurrent reviews, or within thirty (30) working days in the case of retrospective reviews.

2. Information in sixteen (16) of the files indicates that the provider had not been notified by telephone within one (1) working day of making the adverse determination.

3. Information in four (4) of the files indicates that the covered person and/or the provider had not been provided with written or electronic confirmation of the telephonic notification within two (2) working days for the prospective review determinations, within one (1) working day for concurrent review determinations, or within five (5) working days for retrospective reviews.

Recommendation No. 29:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that the timeframes for determination and notification of utilization review decisions meet the requirements of Colorado insurance law.

Issue K2: Failure, in some instances, to provide clear and specific notification in the case of utilization review approvals.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

Section VI. Procedures for Review Decisions

A. A health carrier shall maintain written procedures for making utilization review decisions and for notifying covered persons and providers acting on behalf of covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.

B. For prospective review determinations, a health carrier shall make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, referral, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required. In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, the carrier shall request in writing, within two working days, the additional information needed. The carrier shall allow twenty (20) calendar days to receive the requested information. Within two (2) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination based on the available information and provide notification as specified in paragraphs (1) and (2) below.

   1. In the case of a determination to certify an admission, procedure or service, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the initial certification; and *shall provide written or electronic confirmation of the telephone notification* [emphasis added] to the covered person and/or the provider within two (2) working days of making the initial certification

C. 1. For concurrent review determinations, a health carrier shall make the determination within one (1) working day of obtaining all necessary information.

   2. In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the certification; and shall provide written or electronic confirmation to the covered person and/or the provider within one (1) working day after the telephone notification. *The written or electronic notification shall include the number of extended days or next review date, the new total number of days or*

services approved, and the date of admission or initiation of services.
[Emphasis added.]

APPROVED UR DECISIONS – WRITTEN NOTIFICATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,633	50	13	26%

The examiners reviewed a systematically selected sample of fifty (50) files from a summarized population of 2,633 utilization review approvals made during the examination period of January 1 to December 31, 2002. It appears that the Company is not in compliance with law in that:

1. Notification letters in three (3) of the prospective review files did not clearly indicate that the requested service had been authorized;

2. Notification letters in seven (7) of the concurrent review files did not include documentation regarding the number of extended days or the next review date, the total number of days or services approved, and the date of admission or initiation of services; and

3. Notification letters in three (3) of the files contained a statement the patient would not be notified of the total days authorized and the authorization number until after discharge.

Recommendation No. 30:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its utilization review approval procedures to ensure that the notification sent to members complies with the requirements of Colorado insurance law.

Issue K3: Failure, in some instances, to provide written notice of first level appeal decisions within twenty (20) working days.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

> Section 8. Appeals of Adverse Determinations
>
> A. First Level Appeal Review
>
> 3. *For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal* [emphasis added]...

LEVEL I APPEALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
21	21	6	29%

It appears that, in some instances, the Company is not in compliance with Colorado insurance law in that its review of First Level Appeals did not meet the requirements for responding in a timely manner.

The examiners reviewed the entire population, as represented by the Company, of twenty-one (21) first level appeals for the examination period of January 1 to December 31, 2002. It appears that the Company did not meet the requirements of Colorado law in that information in two (2) of the cases indicated that the Company did not provide written notice of its decision within the required twenty (20) working day timeframe. In an additional four (4) instances, the appeal files provided to the examiners did not contain sufficient documentation to determine when the written notice was provided.

Recommendation No. 31:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that written notification of First Level appeal decisions is completed within the timeframes required by Colorado insurance law.

Issue K4: Failure, in some instances, to include all required components in First Level appeal determination letters.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

> Section 8. Appeals of Adverse Determinations
>
> A. First Level Appeal Review
>
> 3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. *The written decision shall contain*:
>
> a. *The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults.* (For purposes of the section, the physician and the consulting clinical peers shall be called "the reviewers");
>
> b. *A statement of the reviewers' understanding of the reason for the covered person's request for an appeal*;
>
> c. The reviewers' decision in clear terms and the medical rational in sufficient details for the covered person to respond further to the health carrier's position;
>
> d. A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria; and
>
> e. *A description of the process for submitting a grievance in writing requesting a further, second level appeal review of the case.* [Emphases added.]

LEVEL I APPEALS – Written Notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
21	21	19	90%

The examiners reviewed the entire population, as represented by the Company, of twenty-one (21) first level appeals for the examination period of January 1 to December 31, 2002. It appears that the Company did not meet the requirements of Colorado insurance law in that:

1. In seven (7) of the twenty-one (21) cases reviewed, the qualifying credentials of either the reviewing physician or clinical peer reviewer were not provided in the Company's written response. There were six (6) additional cases where the examiners were not provided the appropriate documentation to review this requirement.

2. Additionally, there were six (6) cases where the examiners were unable to determine if the Company's written response contained a statement of the reviewers understanding of the reason for the appeal, and the required information relating to the process for initiating a Second Level appeal due to a lack on documentation in the files.

Recommendation No. 32:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that First Level appeal determination letters contain all the information required by Colorado insurance law.

Issue K5: Failure, in some instances, to conduct first level appeal reviews using physicians who were not involved in the initial adverse determination.

Section 10-16-113, C.R.S., Procedure for denial of benefits, states:

> (3) (b) (II) *The first level appeal shall be a review by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The physician and clinical peer or peers shall not have been involved in the initial denial* [emphasis added]. However, a person that was previously involved with the denial may answer questions…

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

> Section 8. Appeals of Adverse Determinations
>
> A. First Level Appeal Review
>
> 2. *Appeals shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The physician and clinical peer(s) shall not have been involved in the initial adverse decision.* However, a person that was previously involved with the denial may answer questions. [Emphases added.]

LEVEL I APPEALS – Reviewer Procedure

Population	Sample Size	Number of Exceptions	Percentage to Sample
21	21	20	95%

The examiners reviewed the entire population, as represented by the Company, of twenty-one (21) first level appeals for the examination period of January 1 to December 31, 2002. It appears that the Company is not in compliance with Colorado insurance law in that:

1. In seven (7) of the twenty-one (21) cases reviewed, the appeal case was not reviewed by an appropriate clinical peer.

2. In nine (9) of the twenty-one (21) cases reviewed, it appears that the physician who made the original adverse determination was also involved with the review and appeal decision.

3. In four (4) of the twenty-one (21) cases, the examiners were unable to review this information due to a lack of documentation provided by the Company.

Recommendation No. 33:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113, C.R.S., and Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its first level appeal review procedures to ensure compliance with Colorado insurance law.

Issue K6: Failure, in some instances, to notify members fifteen (15) days in advance of the hearing date for second level appeals.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

> Section 8 Appeals of Adverse Determinations
>
> B. Second Level Appeal Review
>
> 3. A health carrier's procedures for conducting a second level panel review shall include the following:
>
> a) The review panel shall schedule and hold a review meeting within forty-five (45) working days of receiving a request from a covered person for a second level review. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person including accommodation for disabilities. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carriers expense, by conference call, video conferencing, or other appropriate technology. *The covered person shall be notified in writing at least fifteen (15) working days in advance of the review date.* [Emphasis added]…

Level II Determinations

Population	Sample Size	Number of Exceptions	Percentage to Sample
5	5	2	40%

It appears that, in some instances, the Company is not in compliance with Colorado insurance law in that its review of Second Level Appeals did not meet the requirements for timely notification to the member regarding the scheduling of a review panel.

The examiners reviewed the entire population, as represented by the Company, of five (5) second level appeals for the examination period of January 1 to December 31, 2002. In two (2) cases, the member requesting the appeal was not notified in writing at least fifteen (15) working days in advance of the scheduled date of the review hearing.

Recommendation No. 34:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its second level appeal review procedures to ensure compliance with Colorado insurance law.

Issue K7: Failure, in some instances, to ensure that second level appeal panels include a majority of health care professionals with appropriate expertise to review the case.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

> Section 8 Appeals of Adverse Determinations
>
> B. Second Level Appeal Review
>
> 2) *A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise* [emphasis added]. Such reviewing health care professionals shall meet the following criteria: not have been directly involved in the care previously; not be a member of the board of directors of the health plan; not have been involved in the review process for the covered person previously; and not have a direct financial interest in the case or the outcome of the review…

LEVEL II APPEALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
5	5	1	20%

The examiners reviewed the entire population, as represented by the Company, of five (5) second level appeals for the examination period of January 1 to December 31, 2002. It appears that the Company was not in compliance with Colorado insurance law in that in one (1) of the five (5) cases reviewed, the majority of members comprising the second level appeal panel did not appear to be health care professionals with appropriate expertise to review the issue being appealed.

Recommendation No. 35:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its second level appeal review procedures to ensure compliance with Colorado insurance law.

Issue K8: Failure to include all the required elements in written notifications of second level appeal rights.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

Section 8 Appeals of Adverse Determinations

B. Second Level Appeal Review

3. A health carrier's procedures for conducting a second level panel review shall include the following:

a. The review panel shall schedule and hold a review meeting within forty-five (45) working days of receiving a request from a covered person for a second level review. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person including accommodation for disabilities. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified in writing at least fifteen (15) working days in advance of the review date.

b) Upon request of a covered person, a health carrier shall provide to the covered person all relevant information that is not confidential or privileged under state or federal law.

c) A covered person has the right to:

1. Attend the second level review;

2. *Present his or her case to the review panel in person or in writing*;

3. *Submit supporting material both before and at the review meeting*;

4. Ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing; and

5. *Be assisted or represented by a person of his or her choice.*

d) *The notice shall advise the covered person of the rights specified in this section 8.I.B…* [Emphases added.]

LEVEL II APPEALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
5	5	5	100%

It appears that the notification of appeal rights disclosure provided by the Company to covered persons requesting a second level appeal does not meet the requirements of Colorado insurance law in that it fails to disclose all mandated rights of the member initiating the appeal. While the Company's disclosure does notify the member of his or her right to appear before the panel, its fails to disclose the right of the Member to:

1. Present his or her case to the review panel in person or in writing;

2. Submit supporting material both before and at the review meeting;

3. Ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing; and

4. Be assisted or represented by a person of his or her choice.

Recommendation No. 36:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all second level appeal notifications disclose all mandated rights of the person initiating the appeal as required by Colorado insurance law.

Issue K9: Failure to include all required elements in the written notification to the covered person of second level appeal decisions, including the right to an independent external review in the case of adverse appeal determinations.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to 10-1-109, 10-3-1107, 10-3-1110 and 10-16-109, C.R.S., states:

> Section 8. Appeals of Adverse Determinations
>
> B. Second Level Appeal Review
>
> 3. A health carrier's procedures for conducting a second level panel review shall include the following:
>
> g. The review panel, after private deliberation, shall issue a written decision to the covered person within five (5) working days of completing the review meeting. The decision shall include:
>
> 1. *The names, titles, and qualifying credentials of the members of the review panel;*
>
> 2. *A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;*
>
> 3. The rationale for the review panel's decision;
>
> 4. *Reference to evidence or documentation considered by the review panel in making that decision*;
>
> 5. *In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination*, and additional appeal, review, arbitration or other options available to the covered person, if any; and
>
> 6. *Effective June 1, 2000, notice of the covered person's right to request an independent external review. The notice shall comply with Section 5 of insurance Regulation 4-2-21*. [Emphases added.]

Regulation 4-2-21, effective June 1, 2000, External Review of Benefit Denial of Health Coverage Plans, promulgated pursuant to 10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states:

Section 5. Notice and Disclosure of Right to External Review

A. (1) A carrier shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in (2) of this Subsection A at the time the carrier sends written notice of carrier's final adverse determination.

(2) *The carrier shall include in the required notice a copy of the description of both the standard and expedited external review procedures the carrier is required to provide pursuant to Subsection B* [emphasis added], including the provisions in the external review procedures that give the covered person or the covered person's designated representative the opportunity to submit new information and including any forms used to process an external review, as specified by the Division of Insurance.

LEVEL II APPEALS – WRITTEN NOTIFICATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
5	5	5	100%

The examiners reviewed the entire population, as represented by the Company, of five (5) second level appeals for the examination period of January 1 to December 31, 2002. It appears that in some instances, the Company was not in compliance with the requirements of Colorado insurance law in that:

1) In all five (5) of the cases reviewed, the Company's written notification to the covered person of the review panel's decision did not contain one or more of the following required disclosure elements pertaining to the decision:

- Names, titles or qualifying credentials of the member of the review panel members;
- Statement of the panel's understanding of the nature of the appeal; or
- Reference to evidence or documentation considered by the panel in making a decision.

2) In the two (2) of the five (5) cases reviewed that were adverse determinations, the Company's written notification to the covered person did not fully disclose one or more of the following required elements pertaining to the covered person's right to an external review and procedures to initiate such a review:

- Instructions for requesting a written statement of the clinical rationale used to make the adverse determination; and
- Notice of the covered persons right to request an independent external review, including the procedures in requesting a standard and expedited external review..

Recommendation No. 37:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-2-17 and 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that second level appeal notifications include all the required elements pertaining to the appeal decision and the person's right to an external review as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

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State Market Conduct Examiners

Jeffory Olson, CIE, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
Maggie Caouette
Amy Gabert
Kit Tucker

For

The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202

participated in this examination and in the preparation of this report.